

APPLICATION FOR COUNTY MEDICAL SERVICES PROGRAM (CMSP)

						COUNTY USE ONLY
1. Name		Date of birth	Social security number		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date: _____
2. Living address (number, street)		City	State	ZIP code	Home telephone number ()	Case number: _____
Mailing address (if different)		City	State	ZIP code	Work telephone number ()	EW name/number: _____
3. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow(er)						County resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. a. List all persons with whom you live:						<input type="checkbox"/> Identification
	Name	Sex	Date of Birth	Social Security Number	Relationship	CMSP Requested
		<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Are any of the persons listed above pregnant? If yes, who is pregnant: _____						<input type="checkbox"/> Yes <input type="checkbox"/> No
c. For CMSP applicants only:						
	Name		Place of Birth (State or Country)		U.S. Citizen	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Do you or any family member have any health insurance which is currently in effect? If you don't have it, is it possible to get it through an employer? If your answer is yes to any of the above, please complete the following:						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Health Insurance		Person(s) Insured		Premium Amount and How Often Paid	
Expiration date (If applicable): / /						<input type="checkbox"/> CMSP 203 completed and sent
6. a. Have you been hospitalized recently or are you currently under a doctor's care? If yes, for what problem? _____						<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs AND has lasted or is expected to last at least one year? If yes, please complete the following:						<input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Person with Problem(s)	Type of Problem(s)	Beginning Date of Problem(s)	Expected Recovery Date if Known		
c. With treatment, do you expect to be able to work in the next year?						<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Are you appealing a social security disability denial?						<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Was the problem(s) listed in 6.a. and b. above caused by an injury or accident?						<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Have you filed a lawsuit or insurance claim?						<input type="checkbox"/> Yes <input type="checkbox"/> No
7. a. Are you or any family member working or expecting to work in the next three months? If yes, please complete the information below and provide proof:						<input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of person working	Employer	Number of Hours Per Week (If hours vary, list average.)	Gross Amount Paid	How Often Paid (weekly, etc.)	
If you are not working, when did you last work?						<input type="checkbox"/> UIB/SDI referral
	Name of person: _____	Month: _____	Year: _____			
	Name of person: _____	Month: _____	Year: _____			
b.						<input type="checkbox"/> LDW: _____
						<input type="checkbox"/> LDP: _____
						<input type="checkbox"/> Last employer

8. If self-employed, has adjusted gross income from last Federal Tax Return changed? Yes No

9. Do you or any family member receive any of the following items free (F) or in exchange for work (W)? Yes No
 If yes, what do you receive?
 F W Rent or housing F W Utilities F W Food F W Clothing

10. How much do you or any family member pay each month for rent/mortgage? \$ _____ utilities: \$ _____

COUNTY USE ONLY

Tax return
 P and Ls
 Unearned
 Earned

11. Have you or any family member applied for, received, or expect to receive any of the following benefits or payments? (Check (☐) and if yes, provide proof.)

Yes	No	Name of person: _____	Yes	No	Name of person: _____
<input type="checkbox"/>	<input type="checkbox"/>	Social security disability or retirement benefits	<input type="checkbox"/>	<input type="checkbox"/>	Social security disability or retirement benefits
<input type="checkbox"/>	<input type="checkbox"/>	SSI/SSP	<input type="checkbox"/>	<input type="checkbox"/>	SSI/SSP
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment insurance	<input type="checkbox"/>	<input type="checkbox"/>	Unemployment insurance
<input type="checkbox"/>	<input type="checkbox"/>	State/private disability insurance	<input type="checkbox"/>	<input type="checkbox"/>	State/private disability insurance
<input type="checkbox"/>	<input type="checkbox"/>	Veterans benefits	<input type="checkbox"/>	<input type="checkbox"/>	Veterans benefits
<input type="checkbox"/>	<input type="checkbox"/>	Child support/alimony	<input type="checkbox"/>	<input type="checkbox"/>	Child support/alimony
<input type="checkbox"/>	<input type="checkbox"/>	Workers Compensation	<input type="checkbox"/>	<input type="checkbox"/>	Workers Compensation
<input type="checkbox"/>	<input type="checkbox"/>	Money from an insurance settlement or a lawsuit	<input type="checkbox"/>	<input type="checkbox"/>	Money from an insurance settlement or a lawsuit
<input type="checkbox"/>	<input type="checkbox"/>	Scholarships, loans, grants	<input type="checkbox"/>	<input type="checkbox"/>	Scholarships, loans, grants
<input type="checkbox"/>	<input type="checkbox"/>	General assistance/general relief	<input type="checkbox"/>	<input type="checkbox"/>	General assistance/general relief
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Total amount expected for this month: \$ _____ Total amount expected for this month: \$ _____

12. Have you or any immediate family member ever been in the U.S. military service? Yes No
 If yes, name of person: _____

13. Are you or any family member the owner of any life insurance, burial insurance, or burial trust? Yes No
 If yes, please complete the following:

Name of person	Company name and address	Type (Burial, Whole or Term life Insurance)	Face Value	Cash Surrender Value
			\$	\$
			\$	\$

14. Do you and any immediate family members have liquid resources, such as cash, checking and savings accounts, stocks, bonds, retirement accounts, certificates of deposit, IRAs, 401Ks, mutual funds, trust accounts, etc.? Yes No

Name of person	Type of account	Bank	Account Number	Balance

15. Do you or any family member have any cars or other motor vehicles, motorcycles, boats, campers, trailers? Yes No

Name of person	Year	Item, Make, and Model	Amount Owed	Does it Run?
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

16. a. Are you or any family member purchasing or do you own a home? Yes No
 If yes, name of person: _____

b. Are you or any family member purchasing or do you own other real property? Yes No
 If yes, name of person: _____

If yes, address (number, street) of home and/or other real property	City	State	ZIP code
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17. Do you or any family member own jewelry items worth more than \$100 each or any other personal property, other than household items? Yes No
 If yes, please list the items and name of person: _____

18. Have you or any family member sold, transferred, or given away any personal or real property in the past two months? Yes No
 If yes, please list the items and name of person: _____

19. Do you or your spouse pay child support, alimony, or child care? If yes, provide proof. Yes No

Amount \$	Name of person who pays	To Whom
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20. Are you or any family member fleeing to avoid prosecution, custody or confinement after conviction for a crime, which is a felony under the law of the place from which he/she flees, or violating a condition of probation or parole imposed under Federal or State Law? Yes No

If yes, name of person: _____

Be sure you have read every item and answered all the questions. Read the following carefully before signing.

- I understand that I am applying for the County Medical Services Program and that I am not applying for the state Medi-Cal program.
- I declare under penalty of perjury that the answers I have given are correct and true to the best of my knowledge.
- I agree to meet all the responsibilities explained in the "County Medical Services Program Rights, Responsibilities, and Other Information" form that I have received.
- I understand that I may be asked to prove my statements and that my eligibility may be subject to a quality control review.
- I understand that the county is required by law to keep all information I provide confidential.

I realize that if I deliberately make false statements or withhold information, I (or the person on whose behalf I am acting) may lose my CMSP card and/or I can be prosecuted for fraud.

Signature of applicant	Date
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Signature of witness (if applicant signed with mark) or person acting for or helping applicant	Relationship	Phone number ()	Date
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